

Thank you for your time!

The Jefferson County Community Care Coalition was developed by community partners to work together in reducing the number of people who are readmitted to a hospital setting within 30 days of their discharge. In an effort to provide resources and educational materials to assist you and other staff who are caring for our community members, we need your input on the effectiveness of this educational presentation and tools.

Care Transitions - Safe Swallowing Education Staff Survey

1. How would you best describe the educational presentation on Dysphasia and Aspiration Pneumonia?

- ☐ I learned information that will be useful in my position
- ☐ It was a good refresher for me, I learned new information
- ☐ It was a refresher for me, but I did not learn anything new
- ☐ I did not learn anything new

2. Which tools/handouts would you use in your position to care for or report on your resident?

Check if or what tools you believe would be helpful:

- ☐ Overview of Swallowing - Dysphagia
- ☐ Stop & Watch – Red Flags for Swallowing difficulty
- ☐ Steps for Safe Feeding
- ☐ Dysphagia Pureed Diet
- ☐ None of these

3. Is there a Stop and Watch Poster - Red Flags for Swallowing difficulty?

	Yes	No
In your residents dining area?	<input type="radio"/>	<input type="radio"/>
In your residents room?	<input type="radio"/>	<input type="radio"/>
Does this visual tool help as a reminder?	<input type="radio"/>	<input type="radio"/>
Is there any information that would improve this tool for you?	<input type="radio"/>	<input type="radio"/>

Please provide an explanation for your answer

4. Would these tools help you care for someone, even if they did not have a diagnosis of dysphagia or aspiration pneumonia?

- ☐ Yes
- ☐ No

Please explain

5. What are other barriers for obtaining the information you need when caring for your resident?

6. What medical conditions, would you like to have this type of training/information/education to increase your comfort in providing care for patients?

- | | |
|---|---|
| <input type="checkbox"/> Dementia/Alzheimer's | <input type="checkbox"/> Infectious disease |
| <input type="checkbox"/> Orthopedic recovery | <input type="checkbox"/> Pneumonia/Flu |
| <input type="checkbox"/> Cardiac/heart | <input type="checkbox"/> Aspiration precautions |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Failure |
| <input type="checkbox"/> Wound Care | <input type="checkbox"/> Pain Medication/Sedation |
| <input type="checkbox"/> Cancer | administering/precaution side effects |
| <input type="checkbox"/> Hospice/End of life | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Renal disease/dialysis | <input type="checkbox"/> G-Tubes |
| Other (please specify) | <input type="checkbox"/> None |

7. Please provide any additional comments:

8. Which type of facility do you work in?

- | | |
|--|--|
| <input type="radio"/> Skilled Nursing Facility | <input type="radio"/> Adult Family Home |
| <input type="radio"/> Assisted Living/CBRF | <input type="radio"/> Supervised Apartment |
| <input type="radio"/> Adult Day Care | <input type="radio"/> In home service provider |
| Other (please specify) | |

9. What is your position?

- | | |
|--|--------------------------------------|
| <input type="radio"/> Care Staff (CNA/PCW/SHC) | <input type="radio"/> Administration |
| <input type="radio"/> Nursing | <input type="radio"/> Housekeeping |
| <input type="radio"/> Dietary | |
| <input type="radio"/> Other (Please specify) | |

Please send paper survey to: Sharon Olson, ADRC of Jefferson, 1541 Annex Rd, Jefferson WI 53549